EXHIBIT 4

POLICE DEPARTMENT, COUNTY OF SUFFOLK, N.Y.

PISTOL LICENSING BUREAU / RELEASE OF MEDICAL RECORDS

PDCS-4409-1

I, , MATTHEW LAMARCO D.O.B [redacted] Social Security Number, [redacted]
residing at 16 TAYLOR ST PT JEFFERSON STATION, NY 11776, do hereby authorize any member, or representative, of the Suffolk County Police Department to seek the release of information contained in all of my records maintained by your office at:

Name of Medical Provider _ CATHOLIC CHARITIES
Address _ 1727 N OCEAN AVE 631-654-1919
_ MEDFORD NY 11763

Further, I hereby authorize your office to release said medical information to any member, or representative, of the Suffolk County Police Department.

The following requested information is necessary in order for the Suffolk County Police Department to complete an investigation to determine the fitness of the above individual to reside in a home with firearms.

Please provide a letter containing the following information:

1. **Reason for treatment;**
2. **List of any medications prescribed, and its effect(s) - possible side effects - on patient;**
3. **Your professional opinion as to the competence of the patient to reside in a home with firearms.**

Please forward the above requested letter to the following;

Suffolk County Police Department
Pistol Licensing Bureau
30 Yaphank Avenue
Yaphank, New York 11980

The requested information is to be forwarded to the Suffolk County Police Department at my request, and will be used by the Suffolk County Police Department for investigative purposes. I am aware that the information disclosed pursuant to this Authorization may be subject to redisclosure and would no longer be protected.

The expiration of this authorization is two years from the date of my signature.

I understand I have the right to revoke this authorization by forwarding written notice to the Suffolk County Police Department or the medical provider specified above. I am aware also that any revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.

I understand I do not have to sign this authorization, and my refusal to sign will not affect my abilities to obtain medical treatment, nor will it affect my eligibility for any benefits. However, I understand that failure to sign this authorization, or revocation of this authorization, will affect my eligibility to possess a pistol license. I further understand I have a right to inspect and copy my protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found in 45 CFR Section 164.524).

I understand this authorization will include information related to (check if applicable and initial):

- ☑ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection (patient initials) ML
- ☑ Behavioral health services / psychiatric care (patient initials) ML
- ☑ Treatment for alcohol and/or drug abuse (patient initials) ML

I understand that I am protected by the law from HIV related discrimination in housing, employment, health care and other services. For more information, I may contact the NYS Division of Human Rights Office of AIDS Discrimination issues at **1-800-523-2437 or (212) 480-2522**, or the New York City Commission of Human Rights at **(212) 306-7500**; these agencies are responsible for protecting my rights.

- OVER -

PLAINTIFF'S EXHIBIT 2 ML 11/16/23
PENGAD 800-631-6989

I authorize the use of my health information as set forth in this document.

Signature of Patient

Dated 5/15/21

Name of Patient (Printed) MATTHEW LA MARCO

Date of Birth [redacted]

Sworn to before me on May 15, 2021

Witnessed by: Richard Fuentes

Notary Public

THOMAS P. LA MARCO
Notary Public, State of New York
No. 52-7407750
Qualified in Suffolk County
Commission Expires May 31, 2022